Workplace Managed Care Research: Successful EAP Models

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I would like to introduce Dr. Paul Roman. Dr. Roman has been a Professor of Sociology and Director of the Center of Research on Behavioral Health and Human Services Delivery at the Institute for Behavioral Research at the University of Georgia since 1986. Previously he was the Favrot Professor of Human Relations and a Professor of Epidemiology at Tulane University between 1969 and 1986. Dr. Roman's research has focused on sociological aspects of alcohol problems with particular attention to the workplace and to the design of prevention efforts focused on employees' substance abuse problems.

He has served on a panel on Employer Policies and Working Families for the National Academy of Sciences, and recently completed service as a member and chair of a Study Section on Alcohol Epidemiology and Prevention at the National Institutes of Health.

His current research is focused on several questions: What are the referral patterns to EAPs that are associated with different types of employee problems? What are the patterns of organizational structures associated with different patterns of success among alcohol treatment service providers? What are the interrelationships between substance abuse treatment and the operation of EAP services?

We are pleased to have Dr. Roman here with us to share his experience in research in working with various businesses and industries. Thank you, Dr. Roman.

Paul M. Roman, Ph.D., Director of the Center for Research on Behavioral Health and Human Services Delivery, Institute for Behavioral Research, University of Georgia:

Thank you, Doctor. I appreciate the kind introduction.

I'm very excited about what is happening at this conference here. I can remember quite easily the early 1970s when occupational alcoholism programs were being launched by the Federal Government, and I was among a group of consultants trying to help design a fledgling movement for change in the workplace. And today a new group is back together here in Tacoma, concerned in many ways with the very same issues.

For what it's worth, I'm probably the most senior person here. My first attendance at a Federally sponsored conference dealing with substance abuse issues in the workplace was in 1967 in Washington at the old Civil Service Commission, now the Office of Personnel Management. The meeting was organized to design the first employee alcoholism policy to be implemented for Federal employees, which was then unveiled with much fanfare by the Chairman of the Commission in 1968, at the 28th International Conference on Alcohol Abuse and Alcoholism at the Shoreham Hotel in Washington. Much has changed since then, but much also has remained the same.

So I go "way back." One of the reasons that I am excited to be here today is that EAPs are kind of children of mine. I helped in the early design and strategizing that eventually led to the widespread adoption of EAPs in the American workplace of today. Yet it is ironic that even after all these years, we've never really found a home for these workplace interventions. The larger community of EAP workers has always tended to "keep its distance" from substance abuse issues, although substance abuse assistance forms the core of a great many EAPs.

The present effort by SAMSHA and CSAP is an incredible opportunity to once again involve the Federal Government in workplace interventions to deal with substance abuse. While many prevention and intervention programs aimed at substance abuse have been adopted throughout American

workplaces, there is much that must be done in terms of quality improvement and ongoing technical assistance. With its unusually broad networks and resource bases, the Federal government has the potential that private foundations and private companies do not have, namely the potential to get a new momentum behind the effort to use the workplace as a primary setting for prevention, early identification, and rehabilitation of employees impacted by substance abuse problems.

To give proper context to what has already occurred in the diffusion and adoption of EAPs and related worksite programs, I would suggest that we have established a sound platform for new and continuing substance abuse interventions. It is not like we are starting from scratch, although a great deal of improvement is needed. But the extent of diffusion of EAPs in the American workplace (about 58 percent of all workplaces, according to our 1997-98 data) is truly remarkable, and thus the platform for continuing efforts is already established.

As Paul Steele described in the preceding presentation, the quality of existing EAP efforts is remarkably variable. Thus while we have a platform, the platform is spongy at certain points, the platform will collapse on certain points, the platform may even be mythical and air-like at other points. But nevertheless, there has been progress, and there has been change.

The workplace efforts to address substance abuse have a common bond of what we might call alienation, for they have occupied a strange place as behavioral interventions in work settings. Within the broader community of substance abuse workers, workplace efforts are not well integrated, not well understood, and thus not always well supported. This can be accounted for in several different ways.

First of all, as has been already pointed out, in the way they operate, EAPs fall between prevention and treatment. Ironically, what adds to their value is that they have preventive impacts and treatment impacts, as I shall demonstrate shortly. But if we look at the broader community of intervention workers, we find they are organized into prevention and into treatment. Thus an effort that includes both thrusts is likely to fall in an "outsider" status as far as the larger organizational efforts are concerned.

As the EAP occupations evolved, they identified themselves with the treatment community. The EAP world attracted clinicians: it attracted clinical psychologists, clinical social workers, and clinical counselors with a variety of different stripes. In the early days it also attracted lots of people who were recovering from their own substance abuse problems who were very anxious to take some of their experience, and very significant talents, and put them to work in the clinical arena. Today most EAP workers with recovery experience have supplemented that experience with professional degrees, and practically none enter field with recovery as their only credential.

The identification with treatment has had its pluses and minuses. The fates of the EAP movement have risen and fallen with the fortunes of treatment. Thus both the EAP and treatment communities grew by leaps and bounds in the 1970s and throughout most of the 1980s, until the crisis in health care costs "cut them off at the pass" and led to crisis and retrenchment during the late 1980s and into the 1990s.

A price paid for the clinical emphasis was difficulty in becoming integrated in the workplace. The workplace operates in a mode that is markedly different from clinical practice and which often defies clinical assumptions. With their clinical emphases, EAPs often failed the communicate the kind of hard-nosed logic that is important in order for a staff function such as EAP to have a significant place at the human resources table. At the extremes, a lot of EAP stuff is soft and mushy, with overtones of "we'll do everything for you that we can," or "we will take care of every problem that you might have." In some instances it almost comes down to the wagging-dog level of, "We'll do anything to be loved." And in some cases this was necessary to gain workplace acceptance.

These "touchy-feely" images were recognized by some, and a reaction emerged among persons struggling to diffuse the EAP concept. In many quarters this new approach had almost a reverse impact. In a rapid effort to change their image to "hard-nosed," EAP specialists began vigorously promoting the "cost savings" associated with EAP implementation. These emphases were loaded with "data" and tended to downplay the helping and humanitarian aspects of programs to the point

of being offensive to experienced managers. By pressing so hard on "savings" in order to be accepted into the workplace, EAP specialists in some instances undermined their credibility and instead came across as salespersons and promoters.

Integrating and interfacing EAPs with the workplace has been their biggest challenge. There are other mistakes that have been made. One of the biggest mistakes, I think, is still very much evident but not even recognized. It is the assumption that EAP referral is an alternative to discipline, an idea that obviously stands in the way of EAP integration into management functioning. Even though this assumption may be contrary to company policy, it is easily fostered by the image of the ever-helpful EAP. Thus it is assumed if employees have a problem that impacts their performance or attendance, or if they have committed some sort of job-related deviance, referral to the EAP is an alternative to being dealt with through the normal disciplinary process.

As I have argued for years, promoting this image was a terrible mistake. It was subtly attractive to supervisors, for they could get problem employees "off their hands" without being "bad guys." But such a stance could easily get the organization into a litigious position, since by offering treatment as an alternative to punishment, the company was practically guaranteeing to employees who were referred to the EAP that the company was going to make them better, and get them back on the job. Litigation could arise when subsequent discipline for poor performance was applied.

By contrast, EAPs should be designed to minimize treatment. By their very design and from the beginning, EAPs were the first significant form of managed care that we ever saw. That's what EAPs were in the very beginning. They had a positive philosophy of managed care built into them, namely, that the EAP can link employees with the most appropriate treatment resource, can get them back to work and on the job, performing successfully in the shortest amount of time with the least amount of financial outlay by either the employee, the company, or the third party payer. That was the original philosophy of EAPs.

But it wasn't always implemented. Despite the potential for savings, treatment costs were often ignored. There were, from the early days, workplaces where all you had to do was report that you drank more than three drinks a day, and you ended up in 28-day treatment, and if you still were drinking three drinks a day after that, you'd end up in 28-day treatment again. This seems preposterous, but it was remarkably common in the 1970s, particularly as inpatient treatment opportunities proliferated and targeted their marketing to workplaces.

Further, the overall EAP field has never been able to effectively organize itself. I respectfully recognize the Employee Assistance Professionals Association, the Employee Assistance Society of North America, but neither of these organizations has ever been able to establish their own collective needs and, thus, they have never been able to lobby very effectively for what they need.

Despite these problems and criticisms, EAPs are institutionalized. As I've already said, they are the platforms and they can be used for new and improved efforts. I'm not in any way asserting the primacy or superiority of EAPs by saying that they are a platform. They ought to be utilized as platforms for further work because they've got preventive potential, they've got treatment potential, and they've got training and educational potentials, all of which need to be further developed.

Quality within EAPs varies, and as Paul Steele's data in the previous presentation indicates, externally-based programs, in general, tend to provide less service than internal programs. While it has characterized much of my own writing, I have come to realize that talking about the internal/external distinction is very problematic. I can take some responsibility for constructing the image that marketing and operating externally-based contract programs defines one segment of the field, while internal programs administered by organizational employees define a second segment.

Characterizations which lump together all internal or all external programs are problematic because there are good quality problems in both types. There is no doubt, however, that workplaces have moved strongly in the direction of choosing external arrangements over internal arrangements. I sincerely doubt that quality issues drive this choice, but rather that external programs represent a lower level of commitment, offer greater flexibility to the client organization in terms of switching vendors, and, in general, are consistent with broader trends whereby workplaces increasingly outsource specialized services.

Internal-external may represent an inappropriate distinction anyway. There is a concept that has been around organizational behavior for a long time, which actually deals with this much more effectively, namely the idea of "coupling." Various activities or roles within organizations can be loosely or tightly coupled into organizational functioning. Coupling is a multi-dimensional concept. A specific function, such as an EAP, is not necessarily tightly coupled to the same functions in every organization, but rather, tightly coupled with this function, loosely coupled with that function, and so forth, depending on the particular structure and culture of the organization and its EAP.

Notable are organizational functions that tend to be loosely coupled from everything else in the organization, which has been the case for many EAPs. What we mean by coupling is the extent to which the EAP is readily available, and prepared to function as an organizational problem-solving device as part of the ongoing complex "action" that makes up a particular workplace. While we have become habituated to talk about workplace programming in clinical terms, "organizational problem solving" is an apt description of a successful intervention with employees who have substance abuse problems. An EAP centered around an 800-number can't perform this function. There's no way they can do it. It is not impossible for externally-based programs to be tightly coupled into the appropriate functions in organizational life, but it takes a lot of proactive effort to bring this about. Without a good,

ongoing working knowledge base about a particular client organization, it is very difficult for an external contractor to pull this off

Another approach to understanding the EAP quality issue is based on the observation that the workplace itself is minimally educated about what it might get from EAP and related interventions. The level of education about substance abuse interventions and EAPs is poorly developed within human resource functions in all sorts and sizes of organizations. Regardless of how informal it may be, the human resource function exists in every organization. Bluntly, those responsible for human resource functions don't know what to expect from EAPs. It is in this arena that governmental partnerships can go a long way toward enhancing the quality of interventions.

In the absence of clear expectations by companies, the external provider follows logical steps in a competitive, capitalistic economy, and says, "I'll tell you what you want, and then I'll sell you what you want. And I'll stay here long enough and I'll figure out what you want so I can sell it to you instead of somebody else selling it to you." The resulting EAPs describe many of the planks in that platform that we have out there, namely the spongy planks and the illusory planks that really consist of only thin air.

How do we foster expectations for the kinds of workplace interventions that really serve the substance abusing employees? In the first place, Table 1 tells us something about the "response set" that we are apt to encounter in the workplace. The idea that drugs are a big problem in the workplace is not widespread. The kind of commitment, interest, level of knowledge, motivation, and education that we find among the companies represented at this conference is not necessarily very widespread. Somehow we have to dovetail the goals of Federal policy along with what our professional associations, EAP vendors, and other influentials are capable of delivering. These in turn have to be dovetailed with the goals of the workplace.

We may have part of the answer right here at this conference. Why are the companies involved in the partnerships in this research? Why are they doing it? We do not understand the linkage between the key features of organizational culture that foster these commitments, which we need to know if we are going to effectively dovetail the goals of substance abuse prevention and treatment and those of productive work organizations.

EAP presence is shown in Table 2. We've measured it a little bit differently than Paul Steele in the RTI study that he presented yesterday. We interviewed a random national sample of full-time employees. And this is kind of interesting, and we vary with RTI by about 10 percent. I believe Paul Steele's figures are about 67% and we show 58%. Now that's really kind of interesting, because what this is showing, is what these employees perceive to exist.

If our percentage was higher than RTI's figures, I would be really concerned. The RTI data comes from a managerial, or human resource representative in the organization. These respondents know for a fact whether an EAP is present. So interestingly, if we compare the two data sets, there are apparently EAPs out there that the human resources department knows about that the employees don't. An EAP that is unknown is not going to attract a lot of use.

The data clearly indicate a steady increase in EAP presence over the past decade. These data are drawn from surveys identical to the most recent one. It is also important to note that, consistent with the RTI data, there is a strong correlation between size and EAP presence, with EAPs far more likely to have been implemented in larger organizations.

Turning to the bottom half of Table 2, we can again demonstrate the platform idea. These are responses to the questions, "Would you use the EAP in your organization for yourself or for a member of your family?" And again, we're talking about probably 2,500 different workplaces

represented in the data set. Nearly half of the respondents show a strong "readiness" to use the EAP. If we combine the bottom two categories, we find 26.4 percent who probably would not use the EAP. Further study of the possible roots of their reluctance is important.

Let's go to Table 3, which describes actual EAP utilization. What is most remarkable is the 12.7 percent of all employees with EAP access have used the EAP for a problem of their own. This level of EAP "penetration" is far greater than I have heard reported from any other survey study. Looking across the other categories (and ignoring the likely possibility of some overlap among the employees reporting in the different categories), we find a substantial degree of exposure to the EAP. These data counter the impression that EAPs are primarily used for problems of dependents rather than by employees themselves. Notably, a relatively small proportion of supervisors have referred a subordinate, a figure that might be expected to be higher since we assume most supervisors have multiple subordinates. This is, however, consistent with the widespread observation that EAPs operate primarily on the basis of self-referrals.

The bottom half of Table 3 is centered on respondents' evaluation of EAP services. We used a strict criteria, reporting here only those responses which indicated high satisfaction or "very helpful." For self-referrals and program use by family members, this "full satisfaction" is found in about half the cases. Reported EAP success is lower among subordinates, and lowest among acquaintances.

The latter figure may be an artifact of respondents simply not knowing about the outcomes. I call your attention to an interesting finding in this table. The "further away" that one gets from an individual's personal experience, the lower the proportion of perceived helpful outcomes. Thus these patterns may simply be an artifact of social distance rather than an indication that EAPs are less effective with certain categories of clients.

These data clearly indicate that there has been a lot of diffusion of EAPs, that there is a lot of familiarity with them, both through personal experience and through knowledge of the experiences of others, and that there is a strikingly high degree of satisfaction with the outcomes that are associated with EAPs. The latter point is an especially tricky one since EAPs are "brokering" operations that coordinate a series of services and behaviors by others. Thus a poor outcome can easily reflect the actions of one of these "others" rather than the quality of the efforts set forth by EAP personnel. But to repeat once again, the evidence is there that there is a firm platform for future efforts to combat workplace substance abuse.

As the workplace is apparently changing to become less hierarchical, we need to understand more about self-referrals. In other words, we would expect that with a "leveling" of statuses in the workplace, it will be less likely for a superior to use leverage to get a subordinate to seek help. On the basis of other studies, we already know that most self-referrals reflect "nudges" from others rather than a "pure" experience of personal revelation that one should seek help for a substance abuse problem.

The disappearance of hierarchy, whether it turns out to be true or not, is welcomed by many. Hierarchy is un-American, and participative management and employee involvement are much more in line with our values and our traditions. Yet, considering peer pressure and peer referrals, as a possible alternative to hierarchical pressure for people to "act," can become quite scary. Starting with the old movie "Lord of the Flies," we can get a flavor of the potential fierceness of peer interaction. At the same time it should be noted that hierarchy and bureaucracy embed a lot of protections for individuals that are difficult to implement in level, "egalitarian" social groups. Thus a better understanding of the alternatives to the classic supervisory referral, namely self- referrals and peer-referrals, should be high on the research agenda.

Looking beyond participative management trends in the workplace, it may also be important to conceptualize the workforce in the context of people being managers of their own human capital. In other words, we may indeed be entering an era when job security is a meaningless idea, where careers have no boundaries, and where success requires repeated re-invention and re-training of oneself.

This suggests, on the plus side, new autonomy and independence. It also suggests that maybe employees themselves are the most accurate diagnosticians when they are in trouble, but only now are they emerging as the masters and mistresses of their own destinies. It has often been the case that you could count on others to cover up your problems, cover for you on the job, and bail you out when you got into trouble.

The workers of tomorrow may have much less to count on if they get into trouble, and I think substance abuse prevention and intervention need to work on that. With credit to the human resources director from Weyerhauser who spoke to us yesterday, there is a huge potential value to education in the workplace which, in a calm and rational way, zeroes in on employees who are emerging as the managers of their own human capital, and says, "This is what substance abuse is, and it can subtly but dramatically interfere with your career and your goals."

Right now we don't do that in adult education about substance abuse. Instead we talk far too much about the dangers of what is really quite ordinary drinking behavior, and our condemnation of drugs borders on the completely irrational. Saying that "Your own human capital is very limited. Substance abuse can really screw it up" makes for a very different message. And a message that might really be heard.

Do EAPs lead to primary prevention? Ever since they were invented, EAPs have been "left out" of the list of significant preventive activities in the substance abuse arena, regarded instead

as a treatment function. This served to reinforce the EAP identity with treatment that I discussed earlier. Our national survey data offers a couple of interesting observations that are summarized in Table 4. There is a statistically significant lowered likelihood that employees in companies with EAPs are current cigarette smokers. This is a surprising finding, as is the next one, namely that what is currently called "binge drinking" is significantly lower among employees in companies with EAPs. With four drinks at a sitting defined as a binge for women, and five at a sitting as a binge for men, it is clear that this behavior is less likely in companies with EAPs. Why? Well, it's possible that companies with EAPs have an overall healthier atmosphere than non-EAP companies, an atmosphere that discourages behaviors that some regard as personally risky and self-destructive.

Can we say that the EAP "causes" these differences? Probably not, but we also cannot say that the EAP's presence is irrelevant to the differences. I have for some time argued that the "crowning" component of the EAP core technology is the transformation of organizational culture into one which incorporates rational attitudes toward psychoactive substances, i.e. promoting moderation or abstinence in use, and "constructive tolerance" (i.e., demanding behavior change but avoiding stigma) in the case of dependence or addiction.

There are several other variables where I looked for differences between employees in companies with and without EAPs. These findings are equally impressive. Depression, as measured by the modified CES-D, is significantly lower among employees in EAP companies. Self-esteem is significantly higher among employees in EAP companies. A well-established "happiness" measure that has been used for over 30 years as a global measure of mental health shows significantly higher score among employees in EAP companies. Finally, in terms of apparent positive prevention, job satisfaction is significantly higher among employees in EAP companies.

Lest I suggest completely miraculous features of EAP, let me note two other interesting findings. There are no statistically significant differences in reports from employees in EAP companies and those in companies without EAPs in the extent of reported work-family conflict and the extent of reported divorce.

In concluding, let me share several important findings from research about EAP components and activities that appear to be effective across a whole range of work settings. One of these findings is that EAP utilization is directly affected by educating supervisors and the workforce about the program and what it can offer. Research has been repeated in a variety of settings that demonstrates, over and over, the efficacy of this education. While this is certainly important data for EAP administrators, it may also point to the potential efficacy of other work-based educational efforts that include a focus on alcohol and drug issues. There may be more potency in this educational base than we have heretofore realized.

A second major finding draws us away from traditional clinical emphases, and focuses on the entire life situation that the substance abusing employee is facing. Work by Thomas McLellan and his associates at the University of Pennsylvania has established that the long-term effects of treating substance abuse are far more dramatic when the intervention addresses the individual's medical, legal, financial, marital, and occupational problems. EAPs are at an excellent vantage point to engage the employee in a comprehensive plan for life change that extends beyond changes in substance using behavior.

Finally, EAPs have unique opportunities for long-term, post-treatment followup of clients that is not available, convenient, or possible in any other sector of the health care delivery system. When you've got an employee who has been through treatment, or has made a valiant attempt to deal with a substance abuse problem, and you've got a resource to which they can turn that will significantly assist them in maintaining that sobriety, that's prevention. And that's good

prevention. And that's the kind of prevention that ought to be acceptable in any kind of policy domain.

I really don't like the term, "relapse prevention" and its pessimistic implications. We are describing something more dynamic than that: sobriety maintenance, sobriety growth, or sobriety promotion. EAPs can really carry out this function, and the use of followup should be a primary criterion for evaluation of EAP effectiveness.

Dr. Jeffery Thompson:

Thank you. How about two questions for Dr. Roman?

Q As you know, back 15 or so years ago, the whole drug-free workplace concept was evolving. We spent a lot of time getting the EAP leadership on board and getting them involved very early. There was a lot of resistance at that time – they just didn't want any part of any program that involved drug testing.

We spent a lot of time and a lot of Government money developing curriculum in substance abuse for EAP professionals. Has the attitude changed? Do you feel that at this point in time there are sufficient numbers of EAP professionals who are really knowledgeable in dealing with substance abuse issues?

A I understand what you are talking about. As you know, EAP workers are largely drawn from clinical specialties. To get a credential in social work or counseling or to receive a Ph.D. in clinical psychology does not require a whit of knowledge about substance abuse. In partial response to this, the EAP field developed their own credential, the Certified Employee Assistance Professional (CEAP) which requires work experience in EAP and successful completion of a written exam. From my vantage point, this certification process is extremely soft and spongy and has very little substance abuse emphasis.

I think the answer is a college-level curriculum which includes course work in substance abuse and in all facets of organizational behavior and human resources management. But as of now, we have practically no initiatives to start such programs. Indeed, substantial energy went into the development of such a curriculum under the leadership of the late Harrison Trice and his colleague, William Sonnenstuhl, but virtually no one, to my knowledge followed their lead, or even attempted to follow it.

You correctly mention that EAP personnel fought the concept of drug testing tooth and nail because they (correctly at the time) thought the whole approach undermined the concept of helping, assistance and human resource conservation. That has changed considerably, and now, in many companies, employees who have positive drug tests at a random or for-cause screen are offered a referral to the EAP.

In terms of relapse prevention or sobriety maintenance, drug testing is the greatest tool we've got, as a followup mechanism with the employee who has been through drug problem treatment. What's neat about drug testing in this context is that it can be a very fair and reasonable bureaucratic tool in the rehabilitation of employees who have really crossed over the line in terms of using illegal substances that are also forbidden by their employers.

Q You mentioned problem resolution and job performance problems. Is there any measure out there that shows how well an EAP is using job performance criteria effectively?

A I have elsewhere suggested that one of the best ways to measure the effectiveness of an EAP is to look at the job performances of former clients several years after they utilized EAP services. There is no instrument that could be used across all work situations which would create common data on this issue. Furthermore, it is important to stress that

improved job performance is not the only possible successful outcome of an EAP intervention.

One effective result of an intervention is somebody departing from the organization. That is a very effective resolution of the problem. Some people don't belong in the jobs that they're in. And in some cases, try to force a round peg into a square hole is virtually what employers have been doing, and, in some cases, the EAP has been helping them do the forcing. Requiring that all EAP clients return to successful performance is unrealistic and reflects tunnel vision.

Table 1

To what extent is drug abuse by employees
a problem at the place where you work?

Major Problem	1.5%
Moderate Problem	4.7%
Minor Problem	23.1%
No Problem at All	7O .7%

Table 2

EAP Presence, 1988: 45%
EAP Presence, 1991: 48%
EAP Presence, 1993: 51 %
EAP Presence, 1995: 55%

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EAP Presence Reported by a Random National Sample of 2500 Employed Persons, 1997-98: 57.8 Percent
(Strongly Correlated with Size of Workplace)

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Would Use EAP for a Problem for Oneself or a Member of One's Family

Very Likely:	45.3%
Somewhat Likely	28.4%
Somewhat Unlikely	13.8%
Very Unlikely	12.6%

Table 3

EAP Utilization

Used the EAP for their own problem:	12.7%
Family member used EAP	7.8%
Referred subordinate (sups. only)	15.7%
Acquaintance at work used EAP	42.7%

Used the EAP for own problem and found it "very helpful:"

52.8%

Family member used EAP and found it "very helpful:"

50.0%

Referred subordinate (sups. only) and found it "very helpful:"

44.0%

Acquaintance at work used EAP and found it "very helpful:"

35.0%

Table 4

Preventive Consequences of EAP Presence?

Cigarette Smoking

EAP Present	24.4%
EAP Absent	31.6%

Drinks Per Occasion When Engaged in Drinking

	EAP Present	EAP Absent
One drink	34.9%	30.8%
Two or three drinks	52.2%	51.1%
Four or five drinks	8.4%	10.5%
Six drinks or more	4.5%	7.6%